



**Evaluation at East Lancashire Hospitals Trust (ELHT) of the impact  
of the Project: 'Supervision Matters: Clinical Supervision for Quality  
Medical Care'.**

**22nd January 2016**

**EVALUATION REPORT  
Commissioned by Health Education England (North West)**

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## **ACKNOWLEDGEMENTS**

We would like to thank all consultants, trainees and executive team members who have taken part in this evaluation. We would also like to thank the Postgraduate Medical Education Department at East Lancashire Hospitals NHS Trust who were so helpful to the evaluation team on site. In addition, our sincere thanks to members of the Evaluation Steering Committee: Prof Anna Sutton, Prof Tim Wright, Prof Helen Simons, Prof Della Fish, Prof Linda de Cossart, Dr Simone Slawik, Ms Catharina Schram, and Dr Shirley Remington. In particular, we thank Prof Helen Simons for her expert advice, support and encouragement throughout the evaluation.

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## **EXECUTIVE SUMMARY**

Edge Hill University was commissioned by Health Education England (North West) to undertake an evaluation of an educational intervention 'Supervision Matters: Clinical Supervision for Quality Medical Care' in January 2015. The evaluation is a case study of the way in which consultants in a Trust (ELHT) experienced this educational intervention, the aim of which was to improve the quality of understanding and practice of the education of postgraduate doctors under supervision. The main method employed was semi structured interviews with module participants (consultant supervisors), their trainees, the teaching faculty and executive team members. These were undertaken between May and October 2015. The interviews were preceded by observations of module teaching sessions to inform the development of the interview schedule. Interviews were interpreted within the context of the Trust's aims for post graduate medical education (PGME). The remit of the evaluation was to report on the following aspects of this educational intervention:

- The starting points for this educational enterprise
- The aims and structure of the module
- The quality of teaching, learning and assessment within the module
- The value of this specific approach to Postgraduate Medical Education (PGME).

## **MAIN FINDINGS**

The approval from the Trust Board to introduce this educational intervention indicates that Trust leaders are committed to improving educational supervision at ELHT. This contributed significantly to consultants' decisions to undertake the module, which was also influenced by the GMC's plans to introduce new approval systems for supervisors.

The commitment shown by the Medical Director and Chief Medical Officer to improve PGME at ELHT provided a positive context in which the teaching faculty could deliver an educational programme that differed fundamentally from traditional forms of PGME. A blended teaching and learning approach was built into the workbooks that were a central part of the teaching in the module as well as the face to face teaching.

Reading the workbooks was very challenging and time-consuming as consultants tried to grasp educational concepts and terminologies used in the workbooks and associated texts. This required far more time for understanding and reflection than most had planned for. However there was no indication from participants that any aspect of the module's content could be reduced or omitted.

The majority of the module participants reported that they felt the module exceeded their expectations and it had the potential to lead to a change in their practice as supervisors. Consultants cited examples of how they intended to embed new ways of working and these included: developing reciprocal support between trainee and supervisor, ensuring trainees prepare for supervisory meetings, and more one to one teaching.

Consultants in interview indicated that the module was extremely helpful for developing their understanding of education and enhancing their supervisory skills. Significant factors which led to this judgement were the modelling in the education process and the personal interest teaching faculty showed in module participants.

The balanced clinical and non-clinical educational profile of the teaching faculty was a key factor in the perceived success by consultants of this blended learning module. This suggests the module's future expansion is dependent on maintaining a teaching faculty that has clinical as well as educational experience.

Interview data demonstrates that consultants intend to increase trainees' expectations of the trainee supervisory relationship and focus more on the trainees' professional development and wellbeing. Half of the trainees interviewed have already begun to see changes in the way their supervisor works. Others have yet to identify new approaches taken by their supervisor.

The fact that approximately ten per cent of the consultant body at ELHT has completed the module provides an impetus for further development. Consultants interviewed explained that changes initially will be quite subtle as they make progress while trying to contextualise their own learning. An informal network of module participants who have built relationships during the module may help to move this forward and begin to form a faculty of educators across the trust.

The module leaders' vision for the development of PGME seems now to be shared by most of the consultants who have attended the module. Further longitudinal investigation is needed to explore if consultants can act on what has been attained through this module and implement consultants' reported intentions to change practice.

## **1 INTRODUCTION**

This is an evaluation report conducted by Edge Hill University (EHU) of an educational project for medical consultants to enhance their supervision and teaching of junior doctors. The level 7 equivalent module 'Clinical Supervision for Quality Medical Care: Supervision Matters' was designed by Professor Linda de Cossart CBE and Professor Della Fish of ED4MEDPRAC Limited (Ltd). The module is in line with the General Medical Council's (GMC) new requirements for the recognition of clinical and educational supervisors and is now accredited by the Academy of Medical Educators (AoME). The aim of this evaluation is to inform the Trust, Health Education England (North West (HEE (NW))), and the directors of ED4MEDPRAC Ltd of the impact that this education intervention has on practice to improve the understanding of, and the quality of, educational practice within the Trust. The remit of the evaluation as submitted to HEE (NW) was to report on the following aspects of this educational intervention:

- The starting points for this educational enterprise
- The aims and structure of the module
- The quality of teaching, learning and assessment within the module
- The value of this specific approach to Postgraduate Medical Education (PGME).

## **2 BACKGROUND**

ELHT is an integrated Health Care Provider located in Lancashire. It provides healthcare services for residents of East Lancashire and Blackburn with Darwen. The Trust employs approximately 7,000 staff across five hospital sites, and various community sites. The originators of the module, Professor de Cossart CBE and Professor Fish, under the auspices of their company ED4MEDPRAC Limited (Ltd), were invited in August 2014 (after detailed discussion at Trust Executive Board level) to engage in an educational intervention at ELHT. This was to improve the quality of the supervision of doctors by supporting the



development of senior medical staff. There were two key drivers behind the Trust Board's decision to invest in this educational intervention. The first was the external reviews by the deanery and the GMC which had highlighted areas for improvement regarding PGME. The second was the fact that the GMC are preparing a process for establishing recognition and approval systems for named educational and clinical supervisors in secondary care to be in place by 31<sup>st</sup> July 2016 (GMC, 2015).

Since then ED4MEDPRAC Ltd have delivered three modules at ELHT. Over 30 consultants have completed the module between September 2014 and October 2015. As part of the overall educational intervention ED4MEDPRAC Ltd have also delivered three one-day workshops on Medical Reflective Writing (for up to 30 people per workshop). These workshops illuminated how clinical decision-making and professional judgement for appraisal could be enhanced, as well as for teaching, learning and developing clinical practice. Plans are also in place to offer other activities aimed at sustaining and developing this educational work with clinical and educational supervisors.

## **2.1 Educational Module**

The module itself, 'Supervision Matters: Clinical Supervision for Quality Medical Care', seeks to extend the educational understanding and practice of clinical and educational supervisors of doctors in a Trust setting. It requires approximately 30 hours of contact time in a blended learning framework, consisting of independent study, course assignments and face-to-face teaching (two half days, two full days and a three-quarter day across four months). This is supported by extensive distance learning resources that become the agenda for deeper discussion on each of the taught days. Embedded in this work is the peer observation of teaching and also the observation of one session of the teaching by Faculty teaching members. Completion of this module requires: 18 writing assignments by the participants which demonstrate the development and extension of their thinking and educational understanding; the reading of 18 papers that offer them knowledge about the wider educational and philosophical literature and how others think about teaching and learning; a portfolio containing the evidence of their development which may be used for one or all of the following: APEL to further level 7 higher education courses; evidence for GMC

registration as a clinical and educational supervisor; appraisal; immediate membership of the Academy of Medical Educators; and resources for teaching.

## **2.2 Module Philosophy and Rationale**

In order to provide a context for understanding the results from the evaluation here is a short description of the philosophy of the module adapted from the originators of the module. The designers of the module have an educational philosophy that is summed up in the phrase "new medical education" where supervisors are seen as educators. The learner is at the centre of the educational endeavour and the teacher needs to understand where the learner is coming from as a start to guide his/her learning. This (i.e. putting the learner and his/her needs at the centre of thinking) is education in the moral mode of practice rather than in the technical mode of practice. This "new medical education" sees teaching, learning and assessment as inextricably linked and medical practice and education as mutually dependent. Furthermore, it offers supervisors new ways of seeing the world and, with an extended language for discourse about educational matters in medicine, helps develop the concepts of the teacher/supervisor (creating supervisors who think like teachers) and the learning doctor, and encourages consultants to see themselves (their being) in new ways (ontology) (See Appendix 2 for further details of this approach).

The rationale, then, of the module is that supervisors are pre-eminently educators. Teaching, in this conception is construed as considerably wider than 'delivering knowledge and skills'. This means that understanding education as a practice and exploring one's own practice in a guided way, is what supervisors of doctors need to do in order to move from a limited way of thinking about, and supervising practicing doctors to a more educationally enlightened practice.

## **2.3 The Module Resources and Teaching**

Two clinicians and two educationalists with expertise in pedagogy designed this module, which is an example of a blended learning approach to teaching and learning. There are

three educational enterprises within this approach, each of which involve differing educational aims and intentions and different forms of teaching and learning. These are:

1. Individual Teaching (and therefore learning) about ways of thinking about education and the practice of teaching, and how these relate to consultants' medical education practices as supervisors. This is accomplished through the booklets, which are a central part of the module, that require several weeks of thinking and writing and investigative activities (related to their own practice), to be completed and brought to the class discussions, having been read beforehand by the class teachers.
2. Group teaching which extends, reinforces and enhances what consultants have been taught (and have learnt) while working through these booklets alone. The facilitated class discussions enable learners to re-construct and enhance as a faculty group what they first learnt/discovered/investigated individually.
3. The individualization of this practical learning by 1:1 observations of each module member's teaching of a supervisee and advisory discussion with an expert in pedagogy followed by a written report to that individual.

The permeating themes are outlined by the originators of the module as: *Being a doctor; Doing as a doctor; Knowing as a doctor; Thinking as a doctor; and Becoming a doctor* can be found in Appendix 3. Appendix 4 outlines the course timetable and the work required by participants. The aims of the module are outlined below.

#### Aspect 1: Teaching (and learning) through the work books

The aims of the written booklets are to enable individual module members to:

- a) consider critically the basic educational principles (including those of learning, teaching and assessment) for the sound and worthwhile supervision of postgraduate doctors, so as to nurture supervisees in recognising clearly what is involved in safe and humane patient care;
- b) attend critically to both the practice of good supervision and its theoretical underpinnings within a framework of an informed understanding of the GMC

standards for recognition and approval of supervisors (clinical and educational).

Appendix 5 outlines the contents of the workbooks.

#### Aspect 2: Teaching and learning as a class group through facilitated discussion of the content of the booklets

The aims of the intentions for each day when the group comes together are outlined on the agenda that is prepared for each day. For example, the agenda for day one states: “The aims for this session are to help you to clarify, consolidate and extend what the study guide has engaged you in thinking about and exploring and enable you to share and critique each other’s ideas and begin to develop a group or even faculty policy about supervision across your hospital and beyond. “

#### Aspect 3: The individualised teaching practice

Faculty teaching members observe a session with the Consultant’s supervisee in order to discuss with them how they both already do or later might utilise what they have learnt on the module to optimise their practice teaching.

### **3 METHODOLOGY**

The methodology adopted was a qualitative case study of medical and surgical consultant’s experience in the ELHT of the module described above, which aimed to improve the quality of understanding and practice of the education of postgraduate doctors under supervision. A case may be identified in many ways. It could be an individual, a programme, an event, an organisation, or a population (Yin, 2003, Stake, 1993, Simons, 2009). In this evaluation the case is the programme, the module referred to above, located within the ELHT. This denotes its geographical boundary and context within which the analysis of the experience of the consultants’ learning in the module can be interpreted and understood.

The main method employed was qualitative semi-structured interviews with module participants (consultant supervisors), their trainees, the teaching faculty and executive team members to gain an understanding of the origin of the initiative, the delivery and the experience of educational practice within the Trust. Seeking understanding from a number

of sources and different perspectives, and interpreting in context (Simons, 2015) are critical features of the case study approach as Lewis (2003) points out:

*The primary defining features of a case study are that it draws in multiple perspectives (whether through single or multiple data collection methods) and is rooted in a specific context which is seen as critical to understanding the research phenomena. ( p. 76)*

The approach is often used when no single perspective can provide a thorough explanation of the concept under investigation (Ritchie, 2003). This sets practical challenges but the evaluation team recognised that, in order to elicit understanding of a complex, innovative experience, it was vital to meet with as many interviewees face to face for in-depth conversation. While interviews were the major method of data gathering, other methods adopted were an analysis of feedback from teaching modules on the course and documentary analysis of teaching materials to provide a frame of reference for questioning in interviews and observations of teaching in practice. Interviews were interpreted within the context of the Trust's aims for post graduate medical education (PGME) and what this might suggest for development of PGME more widely.

### **3.1 Preparation for Data Gathering from Semi-Structured Interviews**

In preparation for the interviews, members of the evaluation team fully immersed themselves with the philosophy and teaching aims of the module and also engaged in three days observation of the module's teaching sessions (Sessions 2, 3 and 4). This was to inform the development of the semi-structured interview schedules that was the prime data gathering method. The evaluation team also conducted documentary analysis of course materials, supervisors' portfolios, and evaluation papers and videos. This further informed the semi-structured interview schedules for the qualitative investigation which is outlined below.

### **3.2 Study Population**

In total 29 Interviews were conducted from May to October 2015. Data collection was split into 4 distinct interview phases. Each phase started in chronological order. However there was an overlap between phases:

- Module participants (consultants)
- Trainees
- Teaching faculty members
- Members of Trust executive team

As set out in the data collection below all the participants (except the teaching faculty members) were employed by ELHT. The majority of interviewees were consultants and their medical trainees.

### 3.3 Data Collection

All potential participants in the four phases of data collection were invited via email to take part in semi-structured interviews. An information sheet (please see Appendix 6) was attached to every recruitment email. Most interviews were face to face meetings at either Blackburn or Burnley hospital sites or the University of Chester. Some interviews were conducted over the telephone when it was too difficult to meet face to face. The table below displays the number of potential participants who were invited to take part and the number of interviews undertaken. Overall, 29 interviews were conducted.

**Table 1: Interview Recruitment Table**

Data collection phases	Invitations	Interviews undertaken
<b>Phase 1: Module participants</b>	23 in total (3 subsequently ineligible)	16 in total
From cohort 1	10	7
From cohort 2	10	9
<b>Phase 2: Trainees</b>	19 in total	7 in total
From cohort 1	4	1
From cohort 2	15	6
<b>Phase 3: Teaching faculty</b>	5	4
<b>Phase 4: Executive team</b>	3	2

Phase 1: As shown in the table above three course participants who had completed the module were no longer eligible to take part. They could not take part due to extended

leave, departure from the Trust, and transference to a later cohort, respectively. Interviews (conducted by JB and PL) took place between May and October 2015. The interviews focused on participants' views about their experience of learning during the module and how this related to the stated module aims and how the module impacted on their practice.

Phase 2: The trainees who had taken part in observed lessons as part of their consultant supervisor's module participation, were also interviewed. These interviews were conducted to explore their learning experiences at ELHT and also whether there had been any noticeable impact on their experiences as a learner since their supervisor had attended the module.

Phase 3: Interviews in this phase focussed on teaching faculty members' perceptions of delivering the module at ELHT. Three were conducted face to face and one over the telephone. The one member of the teaching faculty who did not take part in the interview was willing to participate but an interview could not be arranged in the timeframe available due to their work commitments.

Phase 4: Three executive team members agreed to take part in individual semi-structured interviews on 8th October 2015. However one had to be cancelled by the potential participant at short notice. The two interviews that did take place focussed on the reasons why the educational intervention was introduced and how the module has impacted on the organisation.

### **3.4 Interview Management**

Interviews took place at a time and place convenient to the interviewee. At the time of the interview a consent form was signed by the interviewee. In the case of telephone interviews verbal consent was taken at the start of the call. All interviews were recorded with a digital audio recorder and took between 15 and 40 minutes. Interviews were conversational in style, and semi-structured to allow the interviewer to address themes relevant to the evaluation questions whilst allowing them to follow relevant avenues of inquiry opened by the participants. The current role of the interviewee (and specialty if appropriate) was established at the beginning of the interview.

### **3.5 Analysis**

Interview audio files were transcribed verbatim by an independent professional transcriber. Codes were initially identified independently by JB and PL. This is a process of marking passages of text that identify similarities across transcripts. Categories then began to be identified through multiple readings independently undertaken by JB and PL (Silverman, 2013). Transcripts were also independently analysed by another member of the evaluation team (OC) who was not involved with data collection. This provided a degree of triangulation of the significance of the identified codes and identified categories: OC's identification of codes and emerging categories matched and confirmed JB's and PL's initial analysis. All three members of the team then met to formulate the thematic analysis framework based on the initial codes and refined categories (Ritchie, Spencer & O'Connor, 2003). At this point some of the categories were re-organized under four overarching key themes: motivation and engagement; quality of teaching and learning during the module; impact on practice; and the sustainability of a cultural shift towards a faculty of educators. These were agreed upon quite easily without discrepancy. Please see Appendix 7 for the thematic framework analysis outline.

### **3.6 Use of Quotations from Interviews**

The findings section includes a number of direct quotations from interviewees. These are in italics. The quotations have been selected to represent a significant issue, perception or point of view. Sometimes only one quotation is given though more on the same issue are in the thematic framework data base. Every effort has been made in the narrative to indicate the density of response on any one issue. However this does not exclude the inclusion of an observation or perception from only one person if this is particularly insightful or pertinent to an understanding of the experience. The narrative indicates if this is the case.

### **3.7 Ethical Considerations and Research Governance**

As this study had no involvement with patients, it did not require submission to a National Health Service (NHS) Research Ethics Committee. The evaluation proposal was scrutinized and subsequently approved by the HEE (NW) Research & Development (R&D) Committee (please see Appendix 8) for review and authorisation. The proposal was also approved by



the Faculty of Health & Social Care Research Ethics Committee at Edge Hill University. ELHT R&D Department also scrutinized the proposal and granted organisational permission on 9<sup>th</sup> April 2015 (please see Appendix 9). Letters of ELHT site access were issued on 23<sup>rd</sup> April 2015.

The evaluation interviewers (JB and PL) were experienced researchers with PhDs in Medical Education. All information collected during the study was stored on a secure electronic server at Edge Hill University with access restricted to the evaluation team and the person who transcribed the recording. Processes of recruitment, consent, confidentiality, and storage of data complied with Edge Hill University's framework for research ethics (Edge Hill University, 2014).

## **4 FINDINGS**

The findings reported here, based on the analysis of the 29 recorded interviews, are explored under the four overarching themes identified in the data: motivation and engagement; quality of teaching and learning during the module; impact on practice; and the sustainability of a cultural shift.

### **4.1 Motivation and Engagement**

#### Motivation

Nearly all participants enrolled on the module to develop their supervisory skills. This was important to them especially in light of the new GMC requirements to recognise and approve named educational and clinical supervisors. Some said that they would not necessarily have enrolled without the personal invitation of the Trust's Chief Medical Officer. *The personal letter made a difference* (Consultant Interviewee (C) 1) said this consultant, and the following, who saw it as a privilege to have been chosen.

*It was a named invite by the Chief Medical Officer and at that time I felt that, she used the word handpicked, and I thought, I felt quite privileged, I felt honoured, I felt that somebody in the Trust is recognising your contribution and wanting you to develop even more (C 7).*

All indicated that they wished to further develop their educational practice. Some were well established, senior consultants who had not only undertaken supervisory responsibilities for many years, but had also held educational roles for HEE (NW) and their respective Royal Colleges.

The first module cohort consisted mainly (but not exclusively) of senior consultants who had been invited by the Medical Director and Chief Medical Officer at ELHT. The second cohort included some very experienced consultants but also a more self-selected group of younger consultants. The second module group, one of the teachers observed was *more lively, more kind of committed* (teaching faculty member (TF) 1). What was clear to the teaching faculty was that all participants who attended the module wanted to be there to learn:

*There was certainly no animosity, there was no sort of feeling of them and us, there was a lovely collegiate atmosphere, and I got the impression that the group members were extremely grateful for all that was being offered to them* (TF 4).

The fact that the module had been approved by the Trust Board may have been a contributory factor as to why consultants wanted to attend. One consultant explained that the GMC's new requirements were also influential, '*Changes*' are *coming with GMC regulations and everything else, so I knew I was going to have to get myself in gear* (C 2); another expressed the desire *to lead by example* (C 12); and a third said he thought it looked an interesting challenge and *would give me [an] alternative perspective and help me become a better supervisor* (C 10).

Additional motivation for some was the potential to use this module as preparation for further study, maybe towards a postgraduate qualification in medical education. As one consultant said: *It was mentioned that you could possibly get a PGCert* (C 14). Some consultants, after completing the module, are now considering extending their studies and will actively seek to use their submitted written work to apply for accreditation for prior learning (APEL). This was the intention of the teaching faculty that *it's designed very specifically to enable them to get those credits* (TF 1).

### Engagement with the module

Some consultants seemed more prepared than others for the academic demands of the module. Extensive reading and reflective writing was an integral part of the module and

participants were expected to submit work ahead of each face to face teaching session. The module team organised a pre-course meeting with potential participants to explain the module, introduce the workbooks and outline what to expect. This was confirmed by one interviewee:

*I think when I said I would do it, I hadn't quite appreciated how much time was involved. Although to be fair they [the module leaders] did really emphasize the point, on the first session that this was going to take a lot of time. They had estimated the number of hours that it would take etc, so I can't say that I signed up and wasn't told in black and white (C 14).*

Despite the explanation by the module leaders in the pre-course meeting there was a commonly held view amongst the interviewees that they had not fully realised how much time was needed to read the workbooks and other associated educational texts and submit their written accounts: *It was considerably more time than was suggested that it should take (C 5); It took a lot more than was mentioned. I think that was an underestimation (C6); I think we, as a group, underestimated the time it required to do the reading and then the written work (C 8).*

One consultant explained that the size of the workbooks increased after the pre-course meeting:

*We had the introductory couple of hours, I think that we got the first books there and yes we had to do some work with like a gentle let in so thought oh that's fine that's not a lot. Then the books just got bigger and bigger [laughs] and you think oh god (C 1).*

The same consultant went on to explain that perhaps the module leaders could have given a more realistic explanation of how much commitment and work was required:

*I think it wasn't made clear at the beginning how much work at home it would entail, and I was quite surprised. I think because yes we all study but we haven't worked at that kind of higher degree level. It all took longer than we had been told and finding the time was quite difficult. Having known that beforehand would have been useful, and [would have been] able to take study leave for that work rather than doing it every evening. It was enjoyable but it was quite a punishing four months to do that (C 1).*

Another consultant made a similar point:

*It's a lot more onerous than one would have thought. Not that it would have deterred me from doing it, but because of it – make clearer to people the kind of commitment that's being asked for (C 6).*

Preparatory reading of the booklets and associated educational texts created new challenges for many who were more used to reading medical papers. As one consultant explained: *You had to take in all those chapters. So it's trying to make sense of that, so you can't read it quickly - you've got to give it due attention, and that takes time (C 6).*

The nature of the reading and learning was different from what they normally engaged in. It was not a case of reading abstracts, executive summaries, or short medical papers, it involved in-depth reading before writing down their critiques and reflections.

The module was often described by interviewees as 'intense'. One consultant explained *The work load is massive ... it's a massive commitment, in a system that's already going at full pelt (C 10)*. Although the workload in between face to face sessions was quite demanding and it did, for some, impact on family life, there was overall recognition that it was worthwhile and a valuable learning experience. One consultant summed up a commonly held view amongst the module participants: *I thought the course was excellent, I thought there was a lot of work, and it was a different way of working, but I thought it was very useful (C 2).*

Despite the challenging nature of the module the consultants' own written work was recognised by one participant as a resource they would refer to in the future:

*[I] thought it was going to be challenging, which I thought it was, as it started to get more and more busy, but when I look back at it (and I was looking at it yesterday), [in preparation] for you coming to talk to me and some of the stuff I've written I think, I can go back to it and make use of it for years to come now (C 11).*

Inevitably, there were pressures on time and the need to balance a busy clinical workload while still engaging fully in the module: *I think with your clinical work and your emergency duties and obviously commitment at home, it [i.e educational study] is not always possible (C 14)*. As the following consultant explained, from the experiences of undertaking this module and the impact it had on time outside work, further study would not be undertaken for the time being:

*I think given the current place in my career, my work commitments and my family commitments that amount of work would prevent me from doing anything further until there's some more give in my life (C 10).*

Despite the challenges of workload and pressures on time, it was clear from all interviewees that they valued what they had learned through the module. Learning as a group in particular was considered important. There was a shared view across the whole group of consultant interviewees that they needed to reflect collectively on current educational practices and to reconsider how they engaged with their trainees. The other major point they stressed was: *We [referring to the whole body of consultants] need to be challenged, and they [the teaching faculty] have challenged us (C 6).* This was exactly the purpose of the teaching faculty as one of them explained, *Our intention was to just get them interested, and excited to recognise that this is an intellectual challenge (TF 1).*

Whether the initial motivation for doing the module was their own or prompted by the Trust, in the large majority of cases, participants said that the experience on the blended learning module exceeded their expectations, one consultant adding that it was *the most useful course that I've done since University (C 5).*

## **4.2 Quality of Teaching and Learning in the Module**

This section is divided into two key findings: integration of principles in the teaching process; and impact of different professional perspectives on learning.

### Integration of principles in the teaching process

The teaching faculty consisted of five educationalists, two of whom were also medical professionals. This combination of clinicians and non-clinicians proved to be a significant factor in how the quality of the module's teaching was received by consultants. Consultants wanted clinical experience in the teaching faculty in the classroom and they appreciated it: *Because it's someone who's been there and done it, and you know they've done the working life that you're living. So it's not being delivered by someone who wants to give a view on it but have never done it (C 2); I actually really like the fact, there was a doctor there who actually could bring everything back to medicine (C 4); That sense of understanding, about*

*our role was much better understood by clinicians/educators, rather than just educators (C 16).*

Even more significant was the observation that teachers on the module, as the following consultant pointed out were the very embodiment of the educational principles that underpin the module itself: *They acted as role models during the course (C 16).*

The same consultant noted that the originators of the module *were quite big personalities in themselves*, a point that initially concerned another consultant, but which had subsided with experience of the module.

*If I'm honest at first I was a little bit put off by them because I thought oh my goodness I didn't really know how to take them. Actually as the relationship grew I thought they were very helpful and obviously came with a wealth of experience (C 10).*

Discomfort of a different kind was experienced by the following consultant (C 7) who felt uncomfortable that he was treated by the module team as a *student not a senior consultant* and that teachers *sat at one end of the table*, and were *very much one sided*. He went on to describe the written feedback he received as *very student-like ... which is not taking into account what I've done and what I'm doing (C 7)*. Such discomfort is a familiar issue in the experience of innovation. Quite often there is an initial period of deskilling or, in this case, status difference, which recedes as understanding and experience of a different approach to teaching and learning and the relationship this entails evolves. What the above isolated comments demonstrate are the complexities of managing experienced members of clinical staff in the teaching and learning educational environment.

Teaching sessions were conducted by faculty on a one to one basis or in groups. Participants also delivered their own teaching sessions under the observation of the teaching faculty. The module workbooks provided a sense of progression for the participants as they deconstructed the educational arguments set out in the course material. This was not didactic teaching although one consultant said *it was very much them telling us this is how it should be done (C 7)*. Most however reported that the teachers encouraged discussion and open and honest critical thinking. As acknowledged by the following consultant, *there was never a feeling that the course directors were kind of trying*

to inhibit you from expressing yourself (C 9). Most interviewees welcomed this approach as teachers expected participants to be proactive and 'meet them half way' (TF 2).

This was carefully planned by the teaching faculty:

*One of the things we've taught them is; get the learner to do something first which is exactly what they do, come to the discussion at a higher level, and then you get a really rich development while you're together, and then get the learner to take it further, and that seems to be the message that most of them got, and found that its pleasing, encouraging, and much more enjoyable (TF 1).*

The evaluation team noted during the observed sessions that module leaders strictly adhered to the timetable for the day. This was intentional so participants understood the importance of time and structure. As explained by one of the teaching faculty *one of the big things we teach on this whole thing [the course] is the discipline, and the habits of academic work* (TF 1). The embodiment of the principles underpinning the philosophy of the module in the face to face teaching noted above, were demonstrated and enhanced in the way the teaching faculty provided personal, constructive written feedback soon after assignments were submitted. Most consultants found this practice highly valuable as the following consultant explains:

*The principles they were using, and they were telling us the importance of timely feedback and constructive comments... They were practising what they were preaching, basically. The feedback was given to us at the next meeting and we had time to reflect on the feedback (C 16).*

Feedback during and after the observed teaching sessions was also recognized by participants as a particularly valuable learning opportunity. The observed sessions gave them the chance to demonstrate what they had learnt so far from the module and the feedback allowed them to see what was expected of them from the teaching faculty:

*I think when we did our observed session, being observed, there was clear feedback. So we saw somebody doing it and then that consultant watched me doing it. I think once we did those two, we knew... what they want and can do things like that (C 14).*

### Impact of different professional perspectives on learning

The different professional perspectives of the teaching faculty, mixing educational and clinical experience, added a further important dimension to the module, linking educational practice with patient care:

*They [tutors from both educational and clinical perspectives] seemed to understand our point of view and this made it easier... The whole purpose of this module, the basis of this module, was to show us the parallels between what we do for patient care and how we can use the same principles for caring for our trainees (C 16).*

The actual linking of the care of the patient with the management of trainees relied on the clinical experience of members of the teaching faculty.

Consultants participating in the module also appreciated the clinical experience of colleagues from different specialities. They could see that issues they faced were not theirs alone. Current educational challenges as well as newly formed solutions were discussed cross specialties and, in sharing a similar educational context of supervision, discussions were open and honest: *It actually is a good thing that we are medical, paediatric, gynaecology, surgeons. All of them were represented and the important thing is that the issues we discussed, interestingly, are all the same (C 4);*

These new informal networks initiated in the classroom could well be built upon in the future. Friendships also evolved as the following consultant noted: *Some of them, I had never seen before, but now we are very good friends (C 3).* And others explained that they continued to discuss their experience outside of the classroom setting with those on their module: *It didn't stop there because we talked about it among ourselves, outside the meetings, sort of some verbal reflection on what was going on (C 8).* An executive team member reinforced the importance of this networking opportunity: *seeing educators as being educators and part of a faculty and I think they've learned that building those relationships there's a sense of common purpose (executive team member (ET) interviewee 1).*



### 4.3 Impact on Practice

The previous section focused on what consultants valued and appreciated about their learning in the module, one aspect of which was the interactive and personal nature of how the teaching was conducted. This section takes this a step further and explores how the module has impacted on practice in unforeseen ways. It reports on: modelling opportunities; confidence gained through interactive relationships; and acting differently.

#### Modelling Opportunities

The critical importance of the personal interaction between the trainee and consultant was recognized by all interviewees, one of whom summed it up thus:

*It's about how you conduct yourself, and how the way you conduct yourself, and behave, and how you interact with others. It influences the junior doctors that are coming through. You are a role model so it's about modelling all your interactions (C 2).*

In pursuing this angle in interview an extensive list of modelling opportunities were identified by consultants. These are noted in Appendix 10. It is evident from this list that the module generated many ideas on how supervisors are beginning to facilitate learning in the clinical setting. Many of the examples listed in Appendix 10 under 'intentions to teach', for example, indicate consultants' commitment to the educational and professional wellbeing of the trainee. These include emphasizing the importance of preparation ahead of one to one meetings; encouraging trainees to consider overall their professional development rather than be driven by portfolio requirements; encouraging trainees to be proactive in seeking learning opportunities; adapting their supervisory approach depending on the individual; and developing reciprocal support between trainee and supervisor. Trainees, as indicated in the quotations below, also valued this commitment to their wellbeing.

*What they [the trainees] valued was that the supervisor is someone who is actually interested in the trainee, interested to share experiences (C 1). And also to show flexibility..., and [have] an easy, approachable nature, a non-threatening nature. I think more personal characteristics are important (C 4).*

Ideas for developing practice modelled in the course had already led to new ways of working since undertaking the module as explained here:

*I've done more one on one sessions particularly with my more junior trainee...so it's a lot more personal interaction...specific efforts to give more one on one teaching opportunities asking him; what do you want to do, when you want to find some time, we'll sit down, right what do you want to talk about, what do you want to do and looking at different ways of doing it (C 2);*

*I've started doing new things. When I meet my trainees, I start off with 'where they are', and explore that. I've started using the words 'intentions', 'aims' as opposed to using the word 'objective'. I'm exploring and publicising clinical decision making and professional judgement which I didn't do before (C 7).*

These changes in educational practice and consultants' professional interaction with patients and junior doctors were recognised by half of the trainees. The other half did not report any noticeable change in practice. Here are some examples, from those who had noticed a change that highlight, in turn, the personable style of interaction, the impact of a highly motivated supervisor and the supervisor who cares.

- *'They're very personable, the way they get on with their patients...this has really influenced how I want to be (trainee interview (T) 5);*
- *[if you have] a good supervisor who's highly motivated and motivating, you naturally want to take that extra step to appease them...kind of does rub off (T 3);*
- *Someone that obviously cares about the trainee, beyond just training itself...switched on to the current curriculum...easy to talk to...approachable and quite personable (T 6).*

#### Confidence gained through interactive relationship

It is clear from the data that personal interactions between the supervisor and trainee are a critical element of educational practice beyond the acquisition of technical and medical skills. The significance of this was pointed out by the following consultant:

*[It is] not just adhering to the technical aspect of medical education, so not only ensuring that the trainees or supervisees are aware of the skills, competencies and*

*knowledge but also, the holistic approach...[the] personal perspective in terms of bringing into the personal care what they are as a person, what their beliefs [are], what their assumptions, what their hunches are and education should explore those areas as well as the skills, competency and knowledge (C 7).*

A further benefit of such interaction identified by the following trainee was the boost in his confidence. *I am now more confident to ask questions regarding this problem, according to different patients (T 2).*

And an executive team member noted the roll-on potential impact of this on patient care and safety if trainees had the confidence to challenge their senior colleagues should the need arise:

*If I have got a good relationship with a trainee I've got in theatre, they will be watching my back. If I'm about to do something daft, they'll feel much more confident to say (participant) just, what are you doing that for? And actually, that is going to improve patient safety (ET 2).*

#### Acting differently

Some trainees indicated that consultants who had been on the module behaved differently. One said that they *tended to take a much more proactive and interested role within education, sort of getting trainees involved in all kinds of teaching (T 1).* Another had noticed since the module that their supervisor *had taken on a bit more of a pastoral role, just checking on my wellbeing (T 6).* And a participant from Cohort 1 reported *that juniors who had a supervisor who had been on the course definitely could see the difference (C 15).*

A further example of the impact on those who had been on a course was a noticeable change in emphasis during education meetings. This was reported by trainee 5, *Recently we've been signed off and we've been going through stuff and she's been very much, you know, looking at me self-reflecting, what I could have done, which wasn't really there at the start.*

#### Improved patient care

Consultant, Teachers, Trainees and Trust members interviewed all commented that it is not possible to measure (in the precise sense of that word) the impact that an educational intervention has on patient care. However they did offer many indications of how the

module can influence educational practice and ultimately, patient care. Safety was one issue highlighted. For example, *if you've got a well supervised, well-motivated and educated workforce then it is obviously safer. And the way to get people to deliver better care is to make sure they're well educated* (ET 2).

What this quotation implies is that there are spin off effects of a well-educated workforce that are likely to result in improved patient care. This is an important aspect of senior and junior doctors' education that could well be enhanced within the Trust to develop trainees as all round professionals rather than solely on technical skill acquisition. One consultant explained that the hidden curriculum, for example the subtle interactions between trainees and patients, should be given more of a priority in relation to the grand round. Emphasis should sometimes be on the everyday cases rather than the rare presentations in order to emphasize the importance of basic care and the conduct of the team:

*I think we need to teach much more about the simple everyday things rather than the one in a lifetime exciting things and that cause stress as well, actually what you need 95% of your working life we need to teach that and share it with specialties* (C 2).

#### **4.4 The Sustainability of a Cultural Shift**

##### Trust context

The module which is the subject of this evaluation is innovative, challenging and demanding of consultants' time. Why should a Trust take it on? What led to ELHT's decision to invest in this education programme? The context is summarised by one executive team member:

*Why this piece of work became necessary was we'd had some negative outcomes from our external peer processes about people coming in and reviewing what we were doing. We needed to get behind what was going wrong and clearly one of the things was our approach to our staff who were becoming educators, or needed to become educators* (ET 1).

The Trust Board hoped at the start of this educational intervention that it would lead to *a different approach within the organisation to trainees and what supervision of a trainee*

*meant, and that it would have quite a big paradigm shift in the culture of some of the trainers (ET 2). Members of the Trust Board have now begun to receive feedback from those who attended the module: I think people who've been on the course have benefitted greatly from the conversations that I've had, in a very intensive cramming period taking in a lot of information but they've been able to re-adjust, re-calibrate and re-focus (ET 1).*

The teaching faculty also identified that they were trying to create a critical mass of people in one institution so that a common ethos could be created where people were thinking along the same lines (TF 2). It is important to point out that executive team members reported that there are pockets of excellence within this Trust where medical departments have maintained a high reputation for education and training over many years.

#### The development of a faculty of educators

As indicated in the previous section exploring the tangible impact of this module on practice is difficult at this relatively early stage. *It has helped us all to think slightly differently, said one consultant, adding I think that's where the slow impact will come. How you do things down the line (C 5).*

Executive team members have noted this as well. They have also begun to receive reports that positive changes are emerging. For example, supervisors and consultants have started to challenge each other in departments that have reportedly been offering limited levels of educational supervision in the past.

It is clear from interviews with members of the Trust and consultants, that ELHT are fully committed to education and recognize that educators need support to ensure that all educational and clinical supervisors reach the GMC's new criteria for approving named supervisors. Consultants acknowledged that Trust senior management were committed to the further development of supervision. However, there were concerns expressed about other managers' commitments to PGME at ELHT:

*I don't come, up with any resistance at a senior level...the resistance is at middle management...and that's understandable because ... it's not something that they're being asked to deliver, so their priorities are different (C 12).*

### Current barriers to development

Executive team members understand that some of the rota designs need rethinking to allow such development: *To be honest after you've worked a twelve hour night on an acute medical unit, even if you could be bothered to hang around for the education stuff it's not going to be of any worth* (ET 2). They also explained that the Trust has a particularly demanding Accident & Emergency department. There are also inequalities regarding funding and competing against large teaching hospitals and the impact this has on workforce supply. Consultants have limited time to focus on educational priorities whilst having high clinical workloads. A further barrier reported by some consultants was job planning and its impact on their ability to undertake their supervisory role.

*Job planning is not a very happy element of the job. Let's put it this way. They [consultants] have been put off due to heavy-handedness of the Trust, regarding the job planning, without realising the importance of the medical education and facilitating the supervisors* [C 13];

*We have this phenomenon in the hospital service of job planning. And, although consultants have job plans timed for education and clinical supervision, it's too fluid and doesn't necessarily get used appropriately; and that's one of my challenges, organisationally, is to ring-fence that* (C 8).

Another challenge faced by some supervisors is being located over two hospital sites and therefore *not visible* (C 3) to trainees for half the working week.

### Beginnings of a cultural shift

The experience of the module has shown participants new alternative ways of fulfilling their supervisory duties. This is by incorporating 'teaching the moral mode of practice' which has been a key thread throughout the module. Hopefully participants will continue to find ways to include these in their practice despite the demanding clinical workload.

From what trainees and consultants said and experienced, there is a sense of optimism that the module has started to develop a 'cultural shift' in PGME. Approximately ten per cent of the consultant body have completed the module and the Trust hopes that more will undertake this in the future, so the cultural shift just noted above becomes self-sustaining.

But executive team members believe it may take a few more targeted cohorts to establish such a shift and for this to influence educational practice and ultimately, patient care.

Sustainability of a challenging innovation does not happen overnight and requires continued support. Some of the institutional barriers to establishing such a shift have already been mentioned such as time, access, rota designs and heavy clinical workloads. Add to this the matching of supervisors to trainees, personality differences and preferences for how to teach, and it is clear that sustaining and spreading such a shift requires much effort and commitment. One trainee expressed frustration that all the responsibility is placed on the trainee and never the trainer: *...my educational supervisor is a very, very hard man to track down* (T 4). Another said that they had limited opportunities to learn from their supervisor *I think I'm lacking in supervised teaching here* (T 2). Trainees reported that consultants were completing tasks rather than using it as a teaching opportunity. As one trainee explained *it's quicker for a consultant to do it than for them to spend the time trying to teach me and get me to do it* (T 6).

#### Focusing the effort

From the interviews undertaken there is a wide variation of educational experiences across specialties. To address this variation one consultant explained that he would like to see those leading education at the Trust formally handing teaching and supervisory duties to individuals considered to be good educators. This system may well have to be introduced in any event with the GMC's plans to approve supervisors.

*I think its required for the managers and leaders of education and training to identify the right people to give them the responsibility of teaching and training, rather than anyone who may or may not be interested* (C 8).

The effect of differential support was experienced by the following trainee who pointed out that one department took a great deal of interest in her training whereas another department did not offer one-to-one support.

To make a cultural shift towards a faculty of educators requires a commitment from those who have completed the module to continue to build up their relationships with colleagues across specialties. The Trust now has an informal network of educators who have

completed the module already in place with new ideas to implement. And they have the quality of understanding necessary to extend this role.

The teaching faculty commented on the calibre of many of the individuals they had engaged with at ELHT:

*There's an awful lot of people there we haven't met, but the people we have met, I think, are quality people really and you could meet them in any other hospital of good standing really (TF 2).*

*I find it enjoyably challenging because they want to know things and they don't want to get short changed. They are of course very busy but I think that they do engage with it [the practice of education], most conscientiously (TF 3).*

### Extension of experience

How the effects of the experience may impact further down the line has already been noted. This takes time. Exploring direct changes in educational practice was not possible to achieve in this evaluation given the short time frame and the scheduling of consultants and trainees. At the time of the interviews, trainees had commenced their training posts prior to the start of their supervisors starting the module. Consultants indicated that they needed to start a rotation with a new trainee to fully implement new ways of fulfilling their role as educational supervisors. They suggested that it would be a useful process to re-interview them under a new rota to explore whether any sustainable changes had been implemented. As one consultant explained: *I think it's going to be a subtle impact initially. It will probably realise in six months to twelve months (C 1).* The same consultant went on to say: *The course didn't align itself to the time lines of the training starting (C 1).*

## **5 CONCLUSIONS**

Taking the evidence above into account the conclusions here refer back to the original remit of the evaluation on page 1 and summarize the critical learning from the evaluation on each of the four aspects noted there: the starting points for this educational enterprise; the aims and structure of the module; the quality of teaching, learning and assessment within the module; and the value of this specific approach to Postgraduate Medical Education (PGME).



### **The starting points for this educational enterprise**

The approval from the Trust Board to introduce this educational intervention indicates that Trust leaders are committed to improving educational supervision at ELHT. This contributed to consultants' decisions to undertake the module. Their decision to enrol was also influenced by the GMC's plans to introduce new approval systems for supervisors. The commitment shown by the Medical Director and Chief Medical Officer to improve PGME at ELHT enabled the teaching faculty to deliver the module.

The fact that approximately ten per cent of the consultant body at ELHT has completed the module provides an impetus for further development. It reinforces a willingness of consultants to develop their supervisory skills and, as one consultant put it, *to be challenged, and they [the teaching faculty] have challenged us*.

### **The aims and structure of the module**

The majority of the module participants reported that they felt the module exceeded their expectations and it will potentially lead to a change in their practice as educational and clinical supervisors. In Appendix 10 each indicates what they gained from the module that they would take forward in their practice. These intentions include encouraging trainees to prepare, in writing ahead of one-to-one supervisory sessions, developing reciprocal support between trainee and supervisor, empowering learners, and the intention to adapt and try different things to facilitate learning according to the individual. These are intentions so there may be challenges ahead in incorporating these into everyday practice.

The consultants interviewed reported that it took far more time to undertake the module than they had envisaged which raises some concerns about the sustainability of the module itself. Despite pre-module meetings being organised which encouraged debate regarding expectations some said that if they had known at the outset how much work was involved, they would not have enrolled. Nevertheless with hindsight, once they had completed the module, they did see its value. Module participants found the reading extensive, challenging and time consuming, as they tried to grasp educational concepts and terminologies used in the workbooks and associated texts. This required more time for

consideration and reflection than most had planned for. However, there was no indication from participants that any aspect of the module's content could be reduced or omitted.

### **The quality of teaching, learning and assessment within the module**

From accounts of their experience in interviews all consultants perceived the module to be excellent for developing their understanding of education and enhancing their supervisory skills. Significant factors which led to this perception were the modelling in the education process - teachers *practised what they preached*, consultants said - and the personal interest teaching faculty showed in the module participants. This was demonstrated in the manner in which they facilitated the face to face sessions and provided personalised, timely written feedback. They did not comment on the observed teaching sessions. Sessions ran on time to an agreed timetable. The module leaders' commitment to the educational process was evident. Written submissions, for example, were reviewed thoroughly by members of the teaching faculty and fed back to participants promptly. This encouraged a similar intent from consultants to *meet them halfway* in their commitment to the educational process, despite their heavy clinical workloads.

### **The value of this specific approach to Postgraduate Medical Education (PGME)**

The perceived success of this blended learning module, participants indicated is dependent on those who facilitate the face-to-face sessions and observe the teaching sessions. The mix of 5 educationalists from clinical and non-clinical backgrounds was a vital element in this success. The module leaders were seen as role models for the teaching and learning they aimed to inspire. Consultants interviewed said that they appreciated the benefit of having both educational and clinical tutors, which challenged them both on the educational concepts discussed and interpreting what these meant for clinical practice. This raises questions as to whether this whole approach to PGME can be more widely shared given its reliance on having tutors with both clinical and non-clinical profiles.

Turning to trainees' perceptions of the potential impact of the module on them, some said that they have already begun to see changes in the way their supervisor works and they enjoyed taking part in the one-to-one teaching sessions that were observed by the teaching faculty. Some reported this was a rare experience for them at ELHT. In interviews trainees

also commented that good supervisors show an active interest in their professional and personal wellbeing, mirroring how they treat their patients.

This educational intervention provides an alternative blended learning approach, which in this case is bespoke to the needs of ELHT. The module leaders' vision for the development of PGME is underpinned by the philosophy that a good educator is a clinician who has the ability to engage with patients and use these same interactive personal skills to supervise their trainees. This holistic approach focuses on the development of supervisors as educators rather than trainers. This, arguably, challenges the current systems in PGME which focus on the acquisition of knowledge and skills ahead of work-based assessments and the completion of the trainee portfolio. As already noted, it may take some time for the full impact of the learning from the module to be experienced in the clinical environment as the consultants are still trying to contextualize and implement their learning. Some consultants reported that they needed to start a supervisory relationship with a new trainee before they could incorporate new practices learnt during the module. Further longitudinal investigation is needed to explore whether participants have changed the way they think and practice as clinical and educational supervisors.

The module was not designed for direct cascading of the learning from the module to others. However, some sharing and transfer of learning would be helpful. An informal network of module participants who have reportedly built relationships during the module may help do this. In some cases, for example, the consultant who attended the module was the only one in a department to do so. So to develop a faculty of educators, colleagues will either have to attend the module themselves, learn from others as a result of observing new supervisory practices or discuss possibilities for modifying practice with colleagues.

## **5.1 Limitations of the Project**

This evaluation is a qualitative investigation of a specific educational intervention in ELHT to improve the quality, understanding and practice of the education of postgraduate doctors under supervision. The evaluation documents the perspectives of consultants who undertook the 'Supervision Matters: Clinical Supervision for Quality Medical Care' module based on the interview schedule submitted to the Steering Committee on 5<sup>th</sup> March 2015 (incorporating feedback received on 6<sup>th</sup> and 11<sup>th</sup> March 2015). Neither these questions or

the remit for the evaluation sought direct critique from the evaluators of the educational intervention itself.

The ultimate end of this educational intervention, as stated in the aims of the intervention (outlined on page 4), is to *help nurture supervisees in recognising clearly what is involved in safe and humane patient care*. However, as explained earlier in the findings section, this evaluation could not address this point directly because of its timing. There was no opportunity to observe the consultants implementing any changes inspired by the course with new supervisees. Assessing any direct correlation between the module and its impact on patient care was therefore not possible at this stage. Consultants nevertheless outlined a number of intended practice changes that might in the long term have an impact on better patient care.

A further possible limitation, it could be argued, is the size and nature of the sample on which the conclusions are based and interpreted within the context of ELHT. Those who offered evidence were those who were willing to be interviewed. The evaluation team acknowledge that there may be differing views from those who were invited to interview but chose not to participate.

This study was undertaken over a relatively short period of time, soon after the completion of the module. Both members of the executive team explained that an important indicator for improvement in supervision at ELHT will be more positive trainee feedback during Health Education England visits. A longitudinal investigation may provide more evidence of noticeable changes in practice and a cultural shift in attitudes towards education at ELHT.

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## **Appendix 1    List of Acronyms Used in this Report**

<b>AoME</b>	Academy of Medical Educators
<b>APEL</b>	Accreditation of Prior Experiential Learning
<b>CI</b>	Consultant interviewee
<b>EHU</b>	Edge Hill University
<b>ELHT</b>	East Lancashire Hospitals NHS Trust
<b>EPRC</b>	Evidence-based Practice Research Centre
<b>ET</b>	Executive team member interviewee
<b>GP</b>	General Practitioner
<b>GMC</b>	General Medical Council
<b>HEI</b>	Higher Education Institution
<b>HEE (NW)</b>	Health Education England (North West Team)
<b>NHS</b>	National Health Service
<b>PGCert</b>	Postgraduate Certificate
<b>PGDip</b>	Postgraduate Diploma
<b>PGMI</b>	Postgraduate Medical Institute
<b>TI</b>	Trainee Interviewee
<b>TF</b>	Teaching Faculty member interviewee
<b>UK</b>	United Kingdom

## Appendix 2    Philosophy of Module

### Our philosophy

Della Fish and Linda de Cossart CBE

### Starting points

We believe that the **end product of Medical Education is *medical***.

***The product of undergraduate medical education*** is a doctor now ready to learn further alongside engaging in an appropriate level of medical practice with real patients.

***The product of PGME*** is a practising doctor who is learning the importance of and ability to provide the highest possible quality of wise patient care. This is an endless, open-ended capacity.

### In summary

***The moral mode of practice in PGME*** is about aspiring to understand and make explicit for yourself how you see your practice of medicine, what kinds of education will conduce to developing a wise doctor, using this to critique what external agents require and where necessary seeing these as mere basic requirements and seeking to enrich them in ways which though not required are not precluded.

To paraphrase Pring, 2000, p. 16, we see education as referring to those activities, on the whole formally planned and taught, which bring about learning, that is worthwhile because it contributes to personal well-being, providing the knowledge, understanding and values which enable people to think in the way that is considered worthwhile and to live their lives more fully.

And, crucially, we should recognize the privilege that comes with the education of postgraduate doctors being based on the best and most precious form of teacher / learner interactions, namely one-to-one teaching. Today such opportunities are only found in our two most prestigious UK universities (Oxbridge).



### Appendix 3 The Permeating Themes of the Module

**Being a doctor** is about the whole person you are that you inevitably bring in entirety to your work. **Doing as a doctor** is about the skills you engage in and abilities you harness in the service of patients. **Knowing as a doctor** is about all the knowledge (more than textbook) that you bring to your work. **Thinking as a doctor** is about your decision-making and judgements in respect of patients. **Becoming a doctor** is something you continue to learn throughout your professional life.

Permeating themes that cross all those items in the list below				
Teaching as a practice in its own right	The moral mode of practice	Epistemology and ontology	The importance of reflection	The importance of being; knowing; doing; thinking; and becoming
<b>UNIT A: Dilemmas about myself as a clinician and a teacher</b> A1. What as a person do I bring to my supervision of doctors? A2. What is required of me as a clinician who supervises doctors? A3. How do I see professionalism and why does my view matter? A4. How do I construe the nature of clinical practice and why does this matter? A5. How do I view the nature and status of medical knowledge? A6. How do I see patients and the relative priorities of patients and supervisees? A7. Review: How do I see supervision and the supervisee?				
<b>UNIT B: Dilemmas about teaching</b> B1. How does and how should clinical and educational supervision work in practice for doctors? B2. What is teaching and how would I characterize 'good teaching'? B3. How, in the moral mode of practice, should I engage in teaching my supervisee? B4. What do I see as the basis of my authority and my agency as a supervisor? B5. What is education theory and what do I need to know about it as a supervisor? B6. What do I need to understand about the role of language in supervision? B7. How should I prepare, as a teacher, and how can my teaching be appreciated?				
<b>UNIT C: Dilemmas about learning and my learner</b> <i>(B8 Continuation of work on practical teaching: a writing task)</i> C1. What is involved in negotiation by the educational supervisor of the learning agreement? C2. How can that agreement be turned by the clinical supervisor into a practical curriculum for the learner? C3. How can I study my supervisee/learner and what do I know about the nature of learning? C4. How can I reflect on my own clinical and supervisory practice and teach others to do so? C5. How, as a supervisor, should I now best plan for my supervisees' learning and my teaching? C6. Review: how do I now see learning and supervision?				
<b>UNIT D: Dilemmas about assessment and evaluation</b> D1. What does 'getting the measure of a learner' mean, and how should I do it? D2. What do I need to understand about the nature of work-place based assessment? D3. How can I, in my practice, make assessment more educational? D4. What is educational evaluation and how can I best design it? D5. What have I learnt from being observed, as I teach, by an expert in pedagogy? D7. Final Review				

## **Appendix 4    The Course Timetable and the Work Required by Participants**

### **Welcome Session (1.5 hrs) and Group Interview meeting**

(NOTE: attendance at this initial meeting is essential)

Delegates given *Booklet One*

Pre-prep work for Session 1: half way in *Booklet One*

Approximate work time: 6 hours over two weeks

All required written work by e-mail to Della and Linda by specified date

### **Session 1 (half day)    Facilitated group session to explore work done**

#### **Return of written work**

Pre-prep work for Session 2: Second half of *Booklet One*

Approximate work time: 6 hours over two weeks

All required written work by e-mail to Della and Linda by specified date

### **Session 2 (half day) Facilitated group session to explore work done**

#### **Return of written work**

Delegates given *Booklet Two* and *Resource Booklet*

Pre-prep work for Session 3: Complete *Booklet Two*

Approximate work time: 12 hours over four weeks

All required written work by e-mail to Della and Linda by specified date

### **Session 3 (whole day) Facilitated group session to explore work done**

#### **Return of written work**

Delegates given *Booklet Three*

Pre-prep work for Session 4: Complete *Booklet Three*

Approximate work time: 12 hours over four weeks

All required written work by e-mail to Della and Linda by specified date

### **Peer observation to be arranged in pairs between Sessions 3 and 4**

### **Session 4 (whole day)Facilitated group session to explore work done**

#### **Return of written work**

Delegates given *Booklet Four*

Pre-prep work for Session 4: Complete *Booklet Four*

Approximate work time: 6 hours over two weeks

All required written work by e-mail to Della and Linda by specified date

### **Teaching observation between Sessions 4 and 5**

### **Session 5 (day) Facilitated group session to explore work done**

#### **Return of written work**

Evaluation of the course and Finish

## **Appendix 5    The Contents of the Workbooks for Cohorts 1 and 2**

### ***BOOKLET ONE* Introduction and practical dilemmas Unit A 1-3 (Two weeks study)**

Introductory matters in relation to the uses of this resource material

Practical dilemmas and theoretical perspectives for quality education

#### **UNIT A: Dilemmas about myself as a clinician and a teacher (AoME areas 1, 2 and 6 )**

- A1. What as *a person* do I bring to my supervision of doctors?
- A2. What is required of me as a clinician who supervises doctors?
- A3. How do I see professionalism and why does my view matter?

### ***BOOKLET TWO* Practical dilemmas Unit A 4-7 (Two weeks study)**

#### **UNIT A Dilemmas about myself as a clinician and a teacher    continued**

- A4. How do I construe the nature of clinical practice and why does it matter?
- A5. How do I view the nature and status of medical knowledge?
- A6. How do I see patients and the relative priorities of patients and supervisees?
- A7. Review: How do I see supervision?

### ***BOOKLET THREE* Practical dilemmas Unit B (Four weeks study)**

#### **UNIT B: Dilemmas about supervision and teaching (AoME areas 2 and 3)**

- B1. How does and how should clinical and educational supervision work in practice for doctors?
- B2. What is teaching, what is education and how would I characterize 'good teaching'?
- B3. How, in the moral mode of practice, should I engage in teaching my supervisee?
- B4. What do I see as the basis of my authority and my agency as a supervisor?
- B5. What is education theory and what do I need to know about it as a supervisor?
- B6. What do I need to understand about the role of language in supervision?
- B7. How should I prepare, as a teacher, and what is involved in the appreciation of my practice?

## **BOOKLET FOUR Practical dilemmas Unit C (Four weeks study)**

B8. Continuation of work on practical teaching: a writing task

### **UNIT C: Dilemmas about planning for and facilitating learning (AoME areas 3, 4 and 5)**

C1. What is involved for the Educational and Clinical Supervisor in negotiating the educational agreement and directing the educational action on the ground?

C2. How should I work with my supervisee and what should I know about the nature of learning?

C3. How can learning something practical be turned from training into education?

C4. How should I understand and promote the progress and continuity of each learner?

C5. How, as a supervisor, should I *now* best plan for teaching my supervisee?

## **BOOKLET FIVE Practical dilemmas Unit D (two weeks study)**

### **UNIT D: Dilemmas about assessment and evaluation (AoME areas 5 and 6)**

D1. What does 'getting the measure of a learner' mean, and how should I do it?

D2. What is educational evaluation and how can I best design and use it?

D3. What have I learnt from being observed as I teach, by an expert in pedagogy?

D4. Changing and developing my own and my Trust's educational practice

Appendix Final Review: creating an extended piece of level 7 writing for Appraisal or APEL

## **BOOKLET SIX Reference resources (for use throughout the module)**

- **Theories of teaching and learning: a commentary on foundational 'academic' theories used to inform the practice of education**

Aims and intentions; The role of theory in educational practice; Language in Education; Philosophy; Psychology; Sociology; Conclusion; **Afterword**: a note on Adult Education

- **Reflection for Doctors as a means to learning, and for theorizing medical and educational practice**  
Introduction; Reflection as used in professional practice generally; Reflection for doctors
- **Full reference list**

## **Appendix 6 Participant Information Sheet**

### **Evaluation: 'Supervision Matters: Clinical Supervision for Quality Medical Care'**

You are being invited to take part in a study to explore the impact of the project 'Supervision Matters: Clinical Supervision for Quality Medical Care' at East Lancashire Hospitals NHS Trust. Please take the time to read this information carefully and talk to others about the study if you wish before deciding whether or not to take part.

#### **What is the purpose of this study?**

The aim of this study is to inform the Trust, Health Education North West, and the directors of ED4MEDPRAC Ltd of the education evaluation of the project 'Supervision Matters: Clinical Supervision for Quality Medical Care', and the arising principles and guidelines for working to improve the supervision of doctors within and across one organisation.

#### **Why have I been invited to take part?**

You have been invited to take part as you are either: a course participant; a supervisee of a course participant; a departmental colleague of a course participant; a teaching Faculty member; or a key stake holder at the Trust.

#### **Do I have to take part?**

No, it is up to you to decide if you wish to take part. If you agree to take part in the study you are free to withdraw from the study at any time, without having to give a reason.

#### **What will happen to me if I take part?**

If you let the evaluation team know by email that you are interested to take part in this interview study a member of the team will arrange a time and date for a face to face interview. The researcher will audio record the interview. The interview will last no longer than 40 minutes and we will stop at any time if you wish. The interviews will be transcribed and anonymised and analysed.

#### **What are the possible disadvantages and risk in taking part?**

A small but possible risk is that we may ask questions about your experiences that you find uncomfortable. If this happens we can end the interview. If you need further support we will offer you the opportunity to contact your line manager as per Health Education North West Guidelines or contact Dr Stevie Agius, Senior Research Fellow at Health Education North West.

### **What are the possible benefits?**

It is unlikely that there will be personal benefits, although some people may find it helpful to talk about some of their experiences. The main benefits will be to enable the research team to explore the impact of the course on practice.

### **Will my taking part be kept confidential?**

Yes. Any personal information about you, colleagues, patients or work sites will be removed from the transcripts so that only quotations that are not attributable to any individual will be used in any final reports. Any audio recordings will be kept secure and then destroyed once transcribed and any written information will be kept strictly confidential. Only if the researcher uncovers information that suggests that you, or others, are at risk of coming to any harm, will they break this confidentiality and follow set HEE (NW) reporting processes. The procedures for handling, processing, storage and destruction of data from the study are compliant with the Data Protection Act 1998.

### **What are you going to do with the results of the study?**

The results of this study will be reported to Health Education North West, the Trust and ED4MEDPRAC Ltd. Findings may also be reported in academic journals, and presented at conferences. You will not be identified in any publication. You will be offered a copy of any report arising from the study.

### **Who is organising and funding the research?**

This evaluation is being funded by Health Education North West's Fore Runner Fund.

### **Who has reviewed the study?**

This study has been approved by Health Education North West R&D Committee, the Research Ethics Committee in the Faculty of Health and Social Care, Edge Hill University, and East Lancashire Hospitals NHS Trust R&D Department.

### **What if there is a problem?**

If you are unhappy with the research in any way please tell us. If you would prefer to talk to someone outside the research team or if you are not happy with the way we deal with your problem you can contact Dr Nikki Craske who is the Director of the Research Office at Edge Hill University on 01695 650925 or [nikki.craske@edgehill.ac.uk](mailto:nikki.craske@edgehill.ac.uk).

**Name of researchers** Dr Jeremy Brown, Dr Peter Leadbetter, Oliver Clabburn.

JB and PL will be undertaking the interviews.

**Contact Details** If you would like to ask any other questions please contact: Dr Jeremy Brown, Reader in Health Research, Postgraduate Medical Institute, Faculty of Health & Social Care, Edge Hill University, St Helens Road, Ormskirk, Lancashire L39 4QF.

T. 01695 650919 E. [Jeremy.brown@edgehill.ac.uk](mailto:Jeremy.brown@edgehill.ac.uk)

**Thank you for taking the time to read this information.**

## **Appendix 7    Thematic Framework Analysis of All Interview Transcripts**

### **Motivation and engagement**

Motivation

Engagement with the module

### **Quality of teaching and learning during the module**

Integration of principles in the teaching process

Impact of different professional perspectives in learning

### **Impact on practice**

Modelling opportunities

Confidence gained through interactive relationships

Acting differently

Improved patient care

### **Sustainability of a cultural shift**

Trust context

The development of a faculty of educators

Current barriers to development

Beginning of a cultural shift

Focussing the effort

Extension of experience

## Appendix 8 HEE (NW) Study Approval



### Health Education North West

Our Ref: SA/rjm/

Dr Jeremy Brown  
Reader in Health Research  
Postgraduate Medical Institute  
Faculty of Health & Social Care  
Edge Hill University  
St Helens Road  
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T: 0161 625 7637  
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W: [www.nwpbgmd.nhs.uk](http://www.nwpbgmd.nhs.uk)

15<sup>th</sup> April 2015

Dear Dr Brown, *Jeremy*

### Re: Evaluation: Supervision Matters: Clinical Supervision for Quality Medical Care

I write to confirm that your application for NHS R&D organisational approval by Health Education North West to conduct the above study has been granted.

Approval is given on the understanding that Edge Hill University, as your substantive employer, will act as Sponsor for the research study

You may now proceed with the study as defined in the research protocol. Any amendment to the protocol must be submitted to this office for prior approval.

With best wishes

Yours sincerely

**Dr Steven J Agius**  
**Senior Research Fellow**

*On behalf of Health Education North West: Research Governance Committee*

We are the Local Education and Training Board for the North West

*Developing people  
for health and  
healthcare*

[www.nw.hee.nhs.uk](http://www.nw.hee.nhs.uk)

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## Appendix 9 ELHT R&D Approval

### East Lancashire Hospitals NHS Trust

Ref No. CG/SB  
Our Ref: 2015/019  
Your Ref:  
  
Tel: 01254 733008  
Fax: 01254 733683  
E-Mail: shirley.bibby@elht.nhs.uk

Research and Development  
Level 3  
Royal Blackburn Hospital  
Haslingden Road  
Blackburn  
BB2 3HH

9 April 2015

Dr Jeremy Brown  
Reader in Health Research  
Edge Hill University  
Faculty of Health & Social Care  
St Helens Road  
Ormskirk  
L39 4QF

Dear Dr Brown

**Study:** Evaluation at ELHT of the impact of the Project:  
"Supervision Matter: Clinical Supervision for Quality  
Medical Care"

On the basis of the evidence presented, this project does not require National Research Ethics Service Review under the harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GfREC), but is still classed as research.

I wish to confirm receipt of the following documentation for the above study:

Document	Version	Date
R&D form		25 march 2015
Evaluation Proposal		21 March 2015
Appendices 1 to 8 Emails to potential participants Participant Information Sheet Consent Form Semi-structured interview schedule (draft)	2	12 march 2015

**Safe | Personal | Effective**

The Trust is happy to grant NHS permission and for you to undertake the project as specified in your application. If for any reason you need to amend your study in any way please inform us before this is undertaken. A letter of access will be required if interviews are conducted on NHS premises.

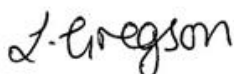
The Trust may wish to monitor your project from time to time. This will involve for example checking details of numbers of participants recruited or samples in the study, reviewing informed consent issues etc. We will inform you in writing if this is the case to make suitable arrangements to undertake the monitoring exercise.

Should the study go ahead it should be noted that:

1. You are required to familiarise yourself and adhere to the requirements of the Research Governance Framework (RGF) in the execution of this research study. (Available at [www.dh.gov.uk](http://www.dh.gov.uk))
2. The study is subject to monitoring and audit by the Research Department.
3. Under the terms of the Research Governance Framework, you are obliged to report any adverse events to the Research Directorate.
4. The Research Directorate should be informed of the outcome of the research, in particular any presentation of the results at scientific and professional meetings or papers published.

Please do not hesitate to contact us on the above number if you have any further queries. Good luck with the project.

Yours sincerely



Catherine Gedling  
**Research & Development Manager**



Interview Number	<div>Extracts from transcript</div> <div>Appendix 10 Extracts from Transcripts</div>
<b>C1</b>	<p>Line number (L) 75: more mentoring and coaching</p> <p>L86: encourage trainees to prep before one to one time and write down areas of discussion</p> <p>L88: observing and mentioning things actually on the ward and signpost areas of further reading</p> <p>L98: not to impart knowledge but encourage the trainees to use the knowledge they have learnt</p> <p>L111: setting up and managing trainees expectations properly with how the learning will happen</p> <p>L114: trainees and consultants being explicit with learning expectations</p> <p>L155: smaller groups of trainees to promote discussion</p> <p>L171: think about service in a different way/perspective</p> <p>L181: being explicit with comments/feedback to trainee</p> <p>L224: keep papers to one side as resources for teaching in the future</p> <p>L235: make notes on trainees when doing ward rounds to discuss with them later on</p> <p>L245: finding and spending time with each trainee (it can be a main barrier)</p> <p>L250: Encourage trainees to prepare and read up for supervision</p> <p>L259: ensure the first session with trainee establishes expectations around self-directed learning</p> <p>L269: must be interested in the trainee and share experiences and want them to grow</p> <p>L278: Encourage trainees to learn how to use and apply their knowledge</p> <p>L290: real life applications of knowledge and how to make the right decisions</p> <p>L297: use the knowledge from a textbook in real life situation, application of the theoretical</p> <p>L314: ensure trainees are aware of the everyday 95% patient ailments, not just the 5% rare special cases that arise</p> <p>L337: encourage trainees to work as part of a team and ask for help when needed</p> <p>L341: create rounded and grounded Dr's who can address patients</p> <p>L355: education is giving people space to think</p> <p>L365: encourage staff to step back and reflect on their performance</p>
<b>C 2</b>	<p>L86: learning to reflect on self as a teacher putting it down on paper- formal reflection</p> <p>L183: understanding individual learning preferences and trying to support the individual</p> <p>L186: "professional relationship" and being supportive of trainees</p> <p>L196: Reciprocal support between trainee and supervisor</p>

	<p>L207: Try to develop working relationship with trainees despite lack of time and split sites</p> <p>L215: ensure educational opportunities are available for trainees with consultants being present on ward everyday</p> <p>L217: can only give an opinion/feedback when you actually know that person</p> <p>L237: everyday there are educational opportunities to better oneself and improve</p> <p>L291: give more one to one sessions with trainees which are driven by what they want to discuss</p> <p>L298: Less PowerPoint and more interactive/trainees in control of the sessions/discussions</p> <p>L335: trainees to understand their role and consultants to understand the trainees background</p> <p>L340: communication has to be 2-way between consultant and trainee</p> <p>L342: consultant must be interested in the person for them to thrive</p> <p>L353: support trainees and ensure they are applied accordingly to their specific interests</p> <p>L371: discrepancy was to what is defined as education- learning on job?</p> <p>L403: as a supervisor, you're a role model and you influence the juniors coming through</p> <p>L433: developing personal/work relationships</p>
<b>C 3</b>	<p>L55: empower the learner</p> <p>L59: encourage the learner to take ownership of their learning</p> <p>L60: face to face discussion around their learning</p> <p>L63: self-learning from trainees and then face to face discussion after</p> <p>L76: trainees read about X and make points to discuss with supervisor- less spoon feeding</p> <p>L156: ensure trainees understand how supervisor works (re: split between 2 sites so little contact)</p> <p>L163: can't physically supervise all trainees as not at the same site as them all the time</p> <p>L187: understand how trainees learn and nurture/develop them accordingly</p> <p>L211: importance of observing trainees and provide feedback</p> <p>L237: is the supervision regular enough, and had enough contact with them</p> <p>L296: involve self as a supervisor, one to one with trainee</p>
<b>C 4</b>	<p>L22: course has had an enormous impact of supervision and how he treats the trainees</p> <p>L25: sessions with trainees are facilitated rather than 'teaching'</p> <p>L37: trainees have contact him asking for more sessions</p> <p>L39: ensure own knowledge is up to date before undertaking supervisions</p> <p>L42: dialogue between self and trainee, 2 way discussion</p> <p>L64: acknowledge the extra time that might be required with trainee</p>

	<p>L77: formal feedback from previous placements and acknowledge variation in trainees skills</p> <p>L92: get to know trainee and their individual strengths, weaknesses, interests etc.</p> <p>L110: ensuring time is spent with trainees and time is found for education</p> <p>L134: supervisors to be flexible, approachable, (151) willingness to develop</p> <p>L172-179:supervising isn't just for the booked few hours, but to create and develop the skills/characteristics to make professionals</p>
<b>C 5</b>	<p>L161: not just teaching facts that can be read up on</p> <p>L167: building and applying trainees current knowledge</p> <p>L435: personalising education according to the individual's specific needs</p> <p>L459: currently do not know their trainees the first placement of the year</p> <p>L596: disconnect with trainees who feel their education is about the completion of their portfolio</p> <p>L629: biggest problem with supervising is about the contact with trainees (and lack of)</p> <p>L686: supervisors must have willingness, open, honest, engaged and have dialogue with trainees</p> <p>L692: develop relationships with the trainees and (699) willingness to consider the learner</p> <p>L719: open mind and figure out the trainee's starting points, try different things to provide learning according to the individual</p> <p>L735: aim to develop the appropriate skills in the juniors to develop lifelong learners</p> <p>L769: not developing the trainees for 'award', but actually want each individual to succeed</p>
<b>C 6</b>	<p>L163: teaching the fundamental role of a Dr and how to actually deal with patients</p> <p>L165: being held accountable for actions</p> <p>L172: cannot train others until you've trained yourself</p> <p>L188: ensuring supervision/teaching is a dialogue and not just one-way</p> <p>L197: teaching trainees but also learning from them too</p> <p>L232: supervisors need to be engaged and up to date with knowledge</p> <p>L238: supervisors willing to always learn, engaged and 2 way dialogue with trainee</p> <p>L253: making sure that opportunities are not lost for trainees- always make time for them</p> <p>L257: all opportunities can be valuable training, eg. talking to patients in the real world</p>
<b>C 7</b>	<p>L162: gain a baseline of where the trainees currently are</p> <p>L163: change of language, using 'intentions and aims' instead of objectives &amp; wants/needs</p> <p>L166: encouraging the trainees to make professional judgment of themselves and their skills</p> <p>L184: skills/tools learnt in course will be esp. useful for starting the next cohort of trainees</p> <p>L195: cascade the info learnt from course with other staff members to further own learning</p>

	L223: supervision is holistic in meeting individual needs and understanding individual perspectives
<b>C 8</b>	<p>L156: create an educational agreement when starting off trainees= setting mutual expectations</p> <p>L163: encouraging self-reflection in trainees</p> <p>L198: ensuring there are opportunities set aside of all of those being supervised</p>
<b>C 9</b>	<p>L150: importance of giving trainees attention</p> <p>L159: rebalance of how teaching occurs- less apprenticeship and more formal training</p> <p>L166: becoming more conscious of the trainees needs</p> <p>L169: future- more structured/meaningful</p> <p>L178: supervisors should: take role seriously, communicate well, understand trainees needs and their backgrounds, tailor training appropriately</p> <p>L186: understand the trainees starting point and try to maximise and both parties being dedicated</p> <p>L191: trainees understand your interest/competence</p> <p>L235: importance of role modelling</p> <p>L239: ensure role modelling doesn't turn into arrogance and fixation of 'the right' things</p> <p>L241: self-critique of self to ensure best teaching</p> <p>L252: observe trainee, explain, critique and ask lots of questions</p>
<b>C 10</b>	<p>L37: course has challenged practice and given aspirational targets</p> <p>L 94: structured time with trainees</p> <p>L96: specific challenges according to individual trainees and shared ideas of progression</p> <p>L146: provide written feedback as it has value and that someone is bothered</p> <p>L150: constructive relationship with trainee and interested in them and educational process</p> <p>L159: provide time for the trainee</p> <p>L174: supervision is not just about ticking boxes in portfolio, but about the holistic approach and moral code of being a doctor.</p>
<b>C 11</b>	<p>L252: ask the trainees questions</p> <p>L254: emphasis on written work from the trainee</p> <p>L256: trainee has to be keen and willing to learn</p> <p>L606: set targets for trainees</p> <p>L639: supervisor knows when the trainee is in need and provides support</p> <p>L658: rapport with trainee and they are confident to approach you as a supervisor</p> <p>L673: taking the time with trainees and being open/honest and available via email/phone</p> <p>L718: moral code of practice- supervising the trainee in a way that is appropriate for him/her</p>

<b>C 12</b>	<p>L301: what do I as a supervisor bring to the teaching, my specific style etc.</p> <p>L312: less osmosis of teaching just sinking in to trainees, more explicit discussions</p> <p>L329: realising when enough time isn't given to trainees and making alternative arrangements with alternative supervisor</p> <p>L346: recognising the importance of regular time and supervisions with trainees</p> <p>L351: ensuring supervisor and trainee personalities match</p> <p>L449: importance of gaining feedback on work and recognising the value of the effort gone into it</p> <p>L525: supervisors need to understand themselves and own practice</p> <p>L530: preparing some material to teach and having an idea of outcomes (557)</p> <p>L550: time/making sure you organise yourself correctly to maximise what time you have</p> <p>L566: barrier for many supervisors is prep work for a supervision, not just off the cuff</p> <p>L600: getting trainees used to receiving feedback</p> <p>L846: being more advert with trainees and try to show how to do things</p> <p>L860: importance of being aware/teaching professional judgment</p> <p>L888: moral judgement is what is brought into teaching and supervisionL902: moving away from osmosis and being more explicit with teaching</p>
<b>C 13</b>	<p>L67: forward planning and preparing before supervision sessions</p> <p>L73: assess where the learner is, where they need to be and how to facilitate that change</p> <p>L83: using principles learnt from course already with trainees</p> <p>L92: supervisor should have baseline of trainee and their targets, needs and goals</p> <p>L95: regular dialogue and meetings and plans for development/needs</p> <p>L100: provide the trainee with opportunities and encourage self-learning direct them as to where to find knowledge</p> <p>L103: dedicated session with trainee that has been planned beforehand / reflective writing</p> <p>L104: 2 way discussion with trainee and encourage their questions</p> <p>L204: trainees encouraged to have more day to day contact with supervisors</p> <p>L206: patient contact is not any different and interlinked with education</p>
<b>C 14</b>	<p>L181: new view of teaching- not just about the actual lecture and being in a classroom, more emphasis upon work before and work after lecture</p> <p>L194: course has taught him/her a new model of how to teach/supervise- 'a new concept'</p> <p>L201: new methods of teaching means less one to one time with trainees- 'limits the time you have to spend with them'</p> <p>L230: carefully trying to balance responsibilities of clinical practice with education</p>

	<p>L232: don't always value the educational opportunity that they as consultants are given</p> <p>L321: supervisors should be nurturing and encouraging</p> <p>L334: trainees are not an extension of self and are people to 'nurture and do really good things'</p> <p>L350: course has made him/her a more thoughtful supervisor than before</p> <p>L379: the trainee has to do the work for optimal learning/teaching- time/effort on their part creates the rewards</p> <p>L387: encouraging trainees to read before supervision and produce something</p> <p>L426: encourage trainees to do their own reading and be responsible for their own learning</p> <p>L483: ensure the trainees don't feel pushed beyond their limits</p> <p>L488: encourage trainees to find information out themselves</p> <p>L512: the importance of teaching trainees how it 'feels' and what it looks like</p>
<b>C 15</b>	<p>L60: try to stimulate trainees in different ways, not so much spoon feeding them</p> <p>L67: more confident to talk to consultants about how they supervise trainees</p> <p>L70: part of your role as an educator is to draw the trainee in and get them engaged</p> <p>L100: observed other consultants on course really thinking hard about how they are going to communicate with juniors differently</p> <p>L149: high quality patient care needs high quality staff education</p> <p>L213: ensure there is available time and be creative in using time efficiently</p> <p>L220: trainees will engage with learning more if they stimulate, and then do more independent learning/reading because they are switched on</p> <p>L228: provide opportunities to learn from a variety of contexts, not just spoon-fed sessions</p> <p>L232: encourage learners to take ownership of their education and seek out what they need</p>
<b>C 16</b>	<p>L322: grasping the importance of timely feedback and constructive comments on submitted work</p> <p>L328: grasping the importance of returning learners' work prior to meetings so they can reflect</p> <p>L356: encouraging supervisees to set learning objectives by doing written reflections</p> <p>L362: promoting supervisees to put thoughts into words means more issues are being considered and discussed which previously remained hidden</p> <p>L431: ensure time and space to arrange sit down meetings and go through their written work</p> <p>L480: time spent with trainees must be worthwhile and collaborative with the supervisory team towards the common goal of patient care</p> <p>L484: keeping the interests of the patient and trainee as a priority for a supervisor</p> <p>L485: making interactions worthwhile</p>